(A) MEDICAL PROGRAMS

- All Employees (excluding employees in the IBEW Union hired prior to 8/1/06)
- Non-Medicare-Eligible Retirees (excluding IBEW employees who retired between 8/1/00 and 7/31/06)
- Non-Medicare-Eligible Participants on LTD (excluding IBEW LTDs terminated between 8/1/00 and 7/31/06)

	CIGNA OAP (PPO)			Vytra PPO		
	In-Network	**Out-of-Network**	**Aetna (HMO)**	**In–Network**	**Out-of-Network**	**HIP (HMO)**
Medical Care Provider	Participating physician/facility	Any physician/facility	Participating physician/facility	Participating physician/facility	Any physician/ facility	Participating physician/facility
Payment of Benefits	No claim forms	Submit claim forms	No claim forms	No claim forms	Submit claim forms	No claim forms
Age Limit for Dependent Children/Full-Time Student	To age 19/ End of the year age 23	To age 19/ End of the year age 23	End of the month age 19/End of the year age 23	To age 19/End of the year age 23	To age 19/End of the year age 23	End of the month age 19/End of the year age 23
Annual Deductible (Indiv/Family)	N/A	$500/$1500	N/A	N/A	$2,000/$4,000	N/A
Annual Out-of-Pocket Maximum (Individual/Family) (Excl Deductible)	N/A	$2,500/7,500	$1,500/$3,000	N/A	$5,000/$10,000	N/A
Lifetime Maximum Benefit	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Pre-Existing Condition Limitation	N/A	N/A	N/A	N/A	N/A	N/A
Office Visits	Covered in full after $20 co-pay PCP/$30 co-pay Specialist	80% of R&C after deductible	Covered in full after $20 co-pay PCP/$25 co-pay Specialist	Covered in full after $20 co-pay PCP/$30 co-pay Specialist	70% of R&C after deductible	Covered in full after $20 co-pay PCP/$30 co-pay Specialist
Emergency Room (Accident)	Covered in full	Emergency: Covered in full Non-emergency: 80% of R&C after deductible	Covered in full after $50 co-pay (waived if admitted)	Emergency: Covered in full after $50 co-pay (waived if admitted)		Covered in full after $50 co-pay (waived if admitted)
(Illness)	Covered in full			Non-emergency: only covered out-of-network: 70% of R&C after deductible		
Inpatient Hospital (Semi-Private Room, Board, Services, Supplies)	Covered in full	Covered in full	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
	Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.			Pre-admission certification required or $250 penalty plus 50% reduction in benefits on any days not approved.		
(Physician)	Covered in full after deductible	80% of R&C	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
(Surgeon)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
Second Surgical Opinion (Office Visit)	Covered in full	100% of R&C	Covered in full after $25 co-pay	Covered in full after $30 co-pay	100% of R&C	Covered in full
Laboratory/X-Ray	Covered in full after deductible	80% of R&C	Covered in full after $25 co-pay	Covered in full	70% of R&C after deductible	Covered in full after $20 co-pay
Maternity (Initial Visit To Determine Pregnancy)	Covered in full after $20 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $20 co-pay
(Subsequent Visits/Delivery)	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
Prescription Medication (Retail)	*$10 generic/ $25 brand formulary $40 brand non-formulary (up to 30-day supply)	Must use in-network pharmacy	$10 generic/$20 brand formulary/ $40 brand non-formulary (up to 30-day supply)	*$10 generic/ $25 brand formulary/ $40 brand non-formulary (up to 30-day supply)	In-network only	$15 generic/$30 brand formulary/ $50 brand non-formulary (up to 30-day supply)
(Mail Order)	*$20 generic/ $50 brand formulary/ $80 brand non-formulary (up to 90-day supply)	Must use in-network benefit	$20 generic/$40 brand formulary/ $80 brand non-formulary (31 to 90-day supply)	*$20 generic/ $50 brand formulary/ $80 brand non-formulary (up to 90-day supply)	In-network only	$22.50 generic/$45 brand formulary/ $150 brand non-formulary (up to 90-day supply)

*After meeting a $100 per person/$300 per family annual drug deductible (R&C = Reasonable & Customary)

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	CIGNA OAP (PPO)		Aetna (HMO)	Vytra PPO		HIP (HMO)
	In-Network	Out-of-Network		In–Network	Out-of-Network	
Preventive Care (Routine Care For Children Including Immunizations)	Covered in full (to age 19)	80% of R&C after deductible (to age 19)	Covered in full (to age 19)	Covered in full (to age 17)	70% of R&C after deductible	Covered in full (to age 19)
(Well Woman Exam)	Covered in full after $20 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full after $20 co-pay	70% of R&C after deductible	Covered in full after $20 co-pay
(Pap Test)	Covered in full	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full w/office visit	70% of R&C after deductible	Covered in full after $20 co-pay
(Mammogram)	Covered in full	80% of R&C after deductible	Covered in full after $25 co-pay	Covered in full	70% of R&C after deductible	Covered in full after $20 co-pay
(Physical Exam)	Covered in full after $20 co-pay if by PCP	Not covered	Covered in full after $25 co-pay	Covered in full after $20 co-pay if by PCP	Not covered	Covered in full after $20 co-pay if by PCP
(Routine Eye Exam)	Not covered	Not covered	Covered in full after $25 co-pay	Covered in full after $30 co-pay (1 exam/year)	Not covered	Covered in full (for optometrist)
Mental Health Care (Inpatient)	Covered in full	Same as inpatient hospital	Covered in full (Max: 35 days/year)	Covered in full	70% of R&C after deductible (Max: 30 days/year combined in/out)	Covered in full (Max: 30 days/year)
(Outpatient)	Covered in full after $30 co-pay /visit	80% of R&C after deductible	Covered in full after $25 co-pay/visit (Max: 20 visits/year)	Covered in full after $30 co-pay	70% of R&C after deductible (Max:20 visits/year combined in/out)	Covered in full after $25 co-pay/visit (Max: 20 visits/year)
Substance Abuse Treatment (Inpatient Detox)	Covered in full	Same as inpatient hospital	Covered in full	Covered in full	70% of R&C after deductible (Max: 3 periods/year combined in/out)	Covered in full (Max: 7 days/year)
(Outpatient Rehab)	Covered in full after $30 co-pay/ visit	80% of R&C after deductible	Covered in full after $25 co-pay/visit (Max: 60 visits/year)	Covered in full $30 co-pay/visit	70% of R&C after deductible (Max: 60 visits/year combined in/out)	Covered in full after $25 co-pay/ visit (Max: 60 visits/year)
Alternate Care (Home Health Care)	Covered in full (Max: 40 visits/year combined in and out of network)	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible (Max: 40 visits/year combined in/out)	Covered in full (Max: 200 visits/year)
(Skilled Nursing Facility)	Covered in full (Max: 60 days/year combined in and out of network)	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible (Max: 45 days/year combined in/out)	Covered in full
(Outpatient Short-Term Rehab: Physical Therapy)	Covered in full after $30 co-pay	80% of R&C after deductible	Covered in full after $25 co-pay (Max: 60 consecutive days/injury/lifetime)	Covered in full after $30 co-pay	70% of R&C after deductible (Max: 60 consecutive days/ injury/ lifetime combined in/out)	Covered in full after $30 co-pay (Max: 90 visits/year)
Durable Medical Equipment	Covered in full	80% of R&C after deductible	Covered in full	Covered in full	70% of R&C after deductible	Covered in full
External Prosthetic Devices	Covered in full	80% of R&C after deductible	Covered in full for initial device only	Covered in full	70% of R&C after deductible	Covered in full
Hearing Aids	Covered in full ----------(Max: $2000/1095 days)----------	80% of R&C after deductible	Not covered	Not covered	Not covered	Not covered